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VICARIOUS LIABILITY OF HOSPITALS*

ARTHUR F. SOUTHWICK**

Legal liability of a hospital for injury to a patient may, depending upon the facts, be based upon either the negligence of the hospital entity itself or upon the doctrine of respondeat superior. The former type of liability is sometimes referred to as corporate negligence and is illustrated by the furnishing of defective equipment, negligence in the selection or retention of incompetent personnel, or the failure to exercise the required degree of care in the maintenance of buildings and grounds. The second type of liability is vicarious. Vicarious liability is the responsibility of A for the wrongful or negligent act of B committed against C when A himself had no part in B's conduct. Literally translated, the doctrine of respondeat superior means "let the master answer" and it operates to render the master liable for the wrongs of his servant and the principal liable for the wrongs of his agent committed while furthering the master's or principal's business. In addition to this liability of the master or principal the negligent or wrongful actor is always individually liable for his act. This paper is concerned with the possible vicarious liability of a hospital for the wrongful or negligent act of a physician, an intern, a nurse, or other person working within the hospital. It is not concerned with the legal responsibility for corporate negligence, nor is it concerned with cases defining negligence or the standard of proof required.¹ Throughout the discussion it shall be assumed that the actor was at fault in causing injury, thereby incurring individual liability to the patient with the issue then becoming whether or not the hospital is also responsible. The patient, of course, has only one recovery. If he is successful in receiving compensation for his loss from the hospital, then it has a legal right to recover from the actor. In practice such right is seldom asserted except as insurance carriers see fit to do so.

The applicability of the doctrine of respondeat superior to a hospital depends, first, upon the type of hospital involved and the law of the particular state in which it exists and, second, upon the type of employment relationship existing between the hospital and the person causing injury to the patient. Involved in the first issue are the doctrines of governmental and charitable immunity whereas the second

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¹ Negligence is defined as "the omission to do something which a reasonable man, guided by those ordinary considerations which ordinarily regulate human affairs, would do, or the doing of something which a reasonable, and prudent man would not do." Black, *Law Dictionary* (3rd ed. 1933).

issue is concerned with the matter of identifying the employment relationship as either master-servant, principal-agent, or employer-independent contractor.

Hospitals are organized as privately-owned, for-profit institutions, privately-owned, non-profit organizations, or governmental hospitals. The private for-profit hospital is termed a proprietary hospital and it may be a corporation, a partnership, or a sole proprietorship. In all states the doctrine of respondeat superior applies to the proprietary hospital inasmuch as it is treated by the law the same as any business that exists for the purpose of making a profit for its owners. Hence, the only issue determining the imposition of vicarious liability is whether or not the negligent actor was an *agent or a servant* of the hospital.

Governmental hospitals may be owned and operated by the federal government, a state government or a political subdivision of the state, such as a municipality or a county. American common law adopted from England the principle that a sovereign government is immune from suit based upon the negligence of the government's agents and servants unless it consents to the suit. The English immunity doctrine was based upon the maxim that the king could do no wrong. Since both the federal government and the various state governments are considered sovereign, their hospitals have traditionally been immune from the application of respondeat superior.

In both England and Canada it is now said that a public governmental body operating a hospital is liable in negligence just as a private individual would be under similar circumstances.² No such sweeping change has yet occurred in the United States.

However, hospitals owned and operated by the United States government are amenable to suit by virtue of the Federal Torts Claim Act, effective retroactively to January 1, 1945.³ All personnel in a federal hospital are considered to be employees of the government rendering it liable for their negligence. This is true for a physician on the staff of the hospital even though the law of some states would consider him to be an independent contractor rather than a servant of the hospital. The hospital is vicariously liable for his malpractice.⁴ Both servicemen injured in federal hospitals "as an incident to the service" and federal prisoners are denied the benefits of the act.⁵ This is for the reason that these people have a distinct federal relationship to the government and they are given the possibility of compensation

² Cassidy v. Ministry of Health, 2 K. B. 343 (1951). Nyberg v. Provost Municipal Hospital Board, 1 Dominion Law Reports 969 (1927).

³ 28 U. S. C. §§1346 (b), 2671-2680 (1950).

⁴ Tessier v. United States, 164 F. Supp. 779 (D. Mass. 1958). Rufino v. United States, 126 F. Supp. 132 (S.D. N.Y., 1954). Dishman v. United States, 93 F. Supp. 567 (D. Md. 1950).

⁵ Feres v. United States, 340 U.S. 135 (1950). Berman v. United States, 170 F. Supp. 107 (E. D. N. Y., 1959).

for injuries under other federal statutes specifically covering their status.

As a general rule, state hospitals are immune from liability unless the common law has been changed by statute. All state functions including the operation of a hospital are governmental. General waivers of immunity are found in four states.⁶ In two states, statutes provide that immunity is waived to the extent of existing liability insurance coverage.⁷ Similarly, Louisiana has held that governmental immunity is not a defense for an insurance carrier although the case did not involve a state hospital.⁸ It has been the general rule that statutory authority granted to state hospitals to sue and to be sued does not constitute a waiver of tort immunity although there is dictum to the contrary in Tennessee.⁹ Courts do not feel free to overrule the immunity of a state as this matter is considered to be purely a function of the legislature. It may be predicted, however, with reasonable certainty that there will be increased legislative activity in this area during the next quarter century as there is evidence to suggest that the attitude toward the role and responsibility of state government is changing.

In regard to the liability of a state's political subdivisions for negligence, some courts have said that a county is an involuntary instrumentality of the state for the performance of governmental functions and, hence, the county automatically possesses the same sovereign immunity as the state.¹⁰ The majority of the courts have, however, approached the problem of county and municipal liability by distinguishing between governmental and proprietary functions. When conducting a governmental function there is immunity. In contrast, the conduct of a proprietary function is in effect competition with private business and the consequence is liability. It is not an easy task to distinguish between governmental and proprietary functions. A given activity may be considered governmental in one state and proprietary in another. In discussing the distinction, the Ohio court, in *City of Wooster v. Arbenz*,¹¹ enunciated certain guiding principles as follows:

In performing those duties which are imposed upon the state as obligations of sovereignty, such as protection from crime, or fires, or contagion, or preserving the peace and health of citi-

⁶ Ala. Comp. Law Ann. §56-7-1, 56-7-7 (Supp. 1958). Ky. Rev. Stat. Ann. §44.070 (Supp. 1958) (Board of Claims hears claims against state for negligent acts and may pay claimant up to \$10,000). N.Y. Court of Claims Act Section 8. N.C. Gen. Stat. §§143-291 (1958) (North Carolina Industrial Commission operates as a court to hear tort claims and may award damages up to \$10,000).

⁷ Del. Code Ann. Title 18, §516 (Supp. 1958). Idaho Code §§41-3304, 41-3305 (Supp. 1957).

⁸ *Rome v. London and Lancashire Indemnity Co.*, 169 So. 132 (La. Ct. App. 1936).

⁹ *Central Hospital for Insane v. Adams*, 134 Tenn. 429, 183 S.W. 1032 (1916).

¹⁰ *Moore v. Walker County*, 236 Ala. 688, 185 So. 175 (1938).

¹¹ 116 Ohio 281, 156 N.E. 210 (1927).

zens and protecting their property, it is settled that the function is governmental, and if the municipality undertakes the performance of those functions, whether voluntarily or by legislative imposition, the municipality becomes an arm of sovereignty and a governmental agency and is entitled to that immunity from liability which is enjoyed by the state itself. If, on the other hand, there is no obligation on the part of the municipality to perform them, but it does in fact do so for the comfort and convenience of its citizens, for which the city is directly compensated by levying assessments upon property or where it is indirectly benefited by growth and prosperity of the city and its inhabitants, and the city has an election whether to do or omit to do those acts, the function is private and proprietary.

Another familiar test is whether the act is for the common good of all the people of the state, or whether it relates to special corporate benefit or profit. In the former class may be mentioned the police, fire, and health departments, and in the latter class utilities to supply water, light, and public markets.¹²

A distinctly different approach and minority view is followed in Alaska where the governmental versus proprietary function concept is not recognized. In that jurisdiction both a county and a municipality are fully liable for the negligence of their servants just as a private business would be.¹³ The same result is reached in New York by statute.¹⁴

Among the majority of the courts which determine county and municipal liability by drawing a distinction between governmental and proprietary functions the weight of authority has held that the operation of a hospital is a governmental function and, hence, there is immunity from tort liability.¹⁵ In contrast a minority of states have determined that the

¹² *Id.* at 284.

¹³ *Tuengel v. City of Sitka*, 118 F. Supp. 399 (D. Alaska 1954).

¹⁴ N.Y. Court of Claims Act, §8. N.Y. General Municipal Law, §50-d. *Becker v. City of New York*, 2 N.Y. 2d 226, 140 N.E. 2d 262 (1957).

¹⁵ *Lee v. Dunklee*, 84 Ariz. 260, 326 P. 2d 1117 (1958); *Calkins v. Newton*, 36 Cal. App. 2d 262, 97 P. 2d 523 (1939); *Waterman v. Los Angeles County General Hospital*, 123 Cal. App. 2d 143, 266 P. 2d 221 (1954); *Talley v. Northern San Diego Hospital District*, 41 Cal. 2d 33, 257 P. 2d 22 (1953); *Durst v. County of Colusa*, 9 Neg. Cases 2d 93, 333 P. 2d 789 (Cal. App. Ct. 1958) (Immunity in county even though plaintiff a paying patient); (Compare statute in California which renders county hospital liable for a dangerous or defective condition of premises, Cal. Govt. Code Ann. Sec. 53050.) *Schwalb v. Connely*, 116 Colo. 195, 179 P. 2d 667 (1947); *Williams v. City of Indianapolis*, 26 Ind. App. 628, 60 N.E. 367 (1901); *Van Pelt v. City of Louisville*, 257 Ky. 256, 77 S.W. 2d 942 (1934); *Thomas v. Board of County Commissioners of Prince George's County*, 200 Md. 554, 92 A. 2d 452 (1952); *Young v. City of Worcester*, 253 Mass. 481, 149 N.E. 204 (1925); *Martinson v. City of Alpena*, 328 Mich. 595, 44 N.W. 2d 148 (1950); *City of Leland v. Leach*, 227 Miss. 558, 86 So. 2d 363 (1956); *Schroeder v. City of St. Louis*, 360 Mo. 293, 228 S.W. 2d 677 (1950); *Kress v. City of Newark*, 8 N.J. 562, 86 A. 2d 185 (1952); *Elliott v. Lea County*, 58 N.M. 147, 267 P. 2d 131 (1954); *Hitchings v. Albemarle Hospital*, 220 F. 2d 716 (4th Cir. 1955); *Lloyd v. City of Toledo*, 42 Ohio App. 36, 180 N.E. 716 (1931); *Hand v. Philadelphia*, 8 Pa. County 213 (1890); *Jerauld County v. St. Paul-Mercury Indemnity Co.*, 76 S.D. 1, 71 N.W. 2d 571 (1955); *Johnson v. Hamilton County*, 156 Tenn.

operation of a hospital by a political subdivision is a proprietary function resulting in liability for negligence of its servants.¹⁶

By the reasoning of the above courts it makes no difference whether the plaintiff was a paying patient or a charity patient. Furthermore, the result is not altered by whether the operation of the hospital by the governmental unit was undertaken voluntarily or whether it was an activity required by state statute. Some jurisdictions, however, have drawn a distinction between a paying patient and a non-paying patient holding that the governmental subdivision is operating in a proprietary capacity as to the former and not the latter.¹⁷ Furthermore, there is some authority to the effect that the activity of operating a hospital is proprietary when it is done in pursuant to a permissive statute, as compared with a mandatory statute requiring the establishment of a hospital.¹⁸

In several states there is a waiver of county and municipal immunity to the extent of existing liability insurance coverage. This result is reached by either judicial decision or statute.¹⁹ In Georgia, any county hospital organized under the Hospital Authority Act is liable by reason of judicial construction of the "sue and be sued" provision of the statute.²⁰ Such is not the general rule.

- 298, 1 S.W. 2d 528 (1927); *McMahon v. Baroness Erlanger Hospital*, (Tenn.) 306 S.W. 2d 41 (1957); *City of Dallas v. Smith*, 130 Tex. 225, 107 S.W. 2d 872 (1937); *City of Richmond v. Long's Adm'r.*, 17 Grat. 375 (Va. 1867); *Gile v. Kennewick Public Hospital District*, 48 Wash. 2d 774, 296 P. 2d 662 (1956). Immunity by statute. Wash. Rev. Code §70.44.060 (1953); *Shaffer v. Monongalia General Hospital*, 135 W. Va. 163, 62 S.E. 2d 795 (1950).
- ¹⁶ *City of Miami v. Oates*, 152 Fla. 21, 10 So. 2d 721 (1942); *Goff v. Fort Lauderdale*, 67 Fla. 324, 65 So. 2d 1 (1953); *Bourgeois v. Dade County*, 243 La. 1, 99 So. 2d 575 (1957); *Moeller v. Hauser*, 237 Minn. 368, 54 N.W. 2d 639 (1952); *Swigard v. Ortonville*, 246 Minn. 339, 75 N.W. 2d 217 (1956); (It should be noted, however, that these two Minnesota cases fail to discuss the doctrine of governmental immunity and simply reach the conclusion that there is liability.) *Kardulas v. Dover*, 99 N.H. 359, 111 A. 2d 327 (1955). (Paying patients; not clear whether rule confined to such.); *Okmulgee v. Carlton*, 180 Okla. 605, 71 P. 2d 722 (1937); *City of Shawnee v. Roush*, 101 Okla. 60, 223 P. 354 (1924); (Oklahoma cases concerned paying patients but it is believed that result not confined to this type of patient).
- ¹⁷ *Beard v. City and County of San Francisco*, 79 Cal. App. 2d 753, 180 P. 2d 744 (1947). (Municipal hospital. Compare California cases *re* county and district hospitals.) *Henderson v. Twin Falls County*, 56 Idaho 124, 50 P. 2d 597 (1935); *Stolp v. City of Arkansas City*, 180 Kan. 197, 303 P. 2d 123 (1956); *Anderson v. City of Portland*, 130 Me. 214, 154 A. 572 (1931).
- ¹⁸ *Wittmer v. Letts*, 248 Iowa 648, 80 N.W. 2d 561 (1957) (Case involved paying patient in a county hospital); *Stolp v. City of Arkansas City*, *supra* note 17.
- ¹⁹ Del. Code Ann. Title 18, §516 (Supp. 1958). Idaho Code §§41-3304, 41-3305 (Supp. 1957). *Tracy v. Davis*, 123 F. Supp. 160 (E. D. Ill. 1954). But see *Moliter v. Kaneland Community Unit District Number 302*, 18 Ill. 2d 11, 163 N.E. 2d 89 (1959); *Rome v. London and Lancashire Indemnity Co. of America*, 232 Ala. 601, 169 So. 132 (1936). Md. Ann. Code Article 48a, §85 (1957). (Not yet authoritatively determined whether or not this statute applies to governmental hospitals. See *Thomas v. Board of County Commissioners of Prince George's County*, 200 Md. 554, 92 A. 2d 452 (1952)). *McMahon v. Baroness Erlanger Hospital*, *supra* note 15.
- ²⁰ *Hospital Authority of Hall County v. Shubert*, 96 Ga. App. 222, 99 S.E. 2d 708 (1957).

The states which by judicial decision follow one or more of the divergent views mentioned regarding county and municipal liability—and New York, which has completely withdrawn immunity by statute—represent an effort and perhaps a trend to eliminate from American law the traditional doctrine of governmental immunity. As governmental subdivisions engage in increasingly widespread activities, the argument that the reason for the doctrine of governmental immunity no longer exists is bound to be heard more often. Future court decisions are likely to restrict the scope of the immunity rule as applied to city and county hospitals and additional statutes concerning the doctrine are not unlikely.

The recent Illinois case of *Molitor v. Kaneland Community Unit District Number 402*²¹ illustrates current judicial philosophy toward governmental immunity. The court overruled prior decisions and held that a school district was liable for the negligence of a bus driver. It argued that a loss caused by a governmental servant should not in view of modern social development be borne solely by the injured individual. Rather the loss should be distributed among the entire community where it can be borne without hardship upon any individual. The court added that a school district can handle its financial problems the same as any private business. The reasoning of the court appears applicable to county and municipal hospitals. Prior decisions, like *Tracy v. Davis*,²² which found a waiver of immunity to the extent of existing liability insurance coverage, are no longer authoritative as the court in the *Molitor* decision felt that this approach was not an adequate answer to the problem. The applicability of the doctrine of respondeat superior in Illinois to a governmental unit is now a question solely for the legislature. It has the choice of permitting the judicial philosophy to prevail or it can re-establish immunity via statute.

CHARITABLE HOSPITAL IMMUNITY

A significant percentage of hospitals in the United States are in the category of privately-incorporated, non-profit institutions. These are also termed voluntary or charitable hospitals. Whether a given organization is charitable is determined by what its charter provides and by its actual operation. The essence of establishing the charitable characteristic is that there must be no private profit for any individual or group. The fact that certain departments of the hospital or even the fact that the institution as a whole earns a profit is immaterial so long as the profit inures to the benefit of the organization as a charity, as contrasted with a private profit. A hospital does not lose its charitable status by admitting paying patients or by enforcing its legal right

²¹ See *supra* note 19.

²² 123 F. Supp. 160 (E.D. Ill. 1954).

to payment of the account. The charitable hospital does jeopardize its status, contrary to the position of a private for-profit hospital, if it summarily rejects a patient on the sole basis that he is unable to pay for his care. However, it is to be emphasized that the extent to which free service is rendered is not conclusive on the issue of whether or not a given institution is charitable and, conversely, the fact that a private for-profit hospital sometimes renders free service does not make it charitable.

Once the charitable status of a medical care institution is established, an immediate question arises regarding the applicability of the doctrine of respondeat superior. Historically, the law of the majority of the states has held the charitable institution immune from the negligence of its agents and servants and hence respondeat superior has not been applied. There is a definite and apparently conclusive trend away from this position and toward liability. Today the law in this area varies from complete immunity to complete liability, with a number of states assuming compromise positions.

The beginning of charitable immunity in the United States is found in the case of *McDonald v. Massachusetts General Hospital*.²³ It was there held that the funds of a charitable hospital constitute a trust fund and as such may not be depleted and diverted from the intended purpose of public charity to the payment of compensation to persons injured by the negligence of the hospital's servants so long as the administrators of the trust have selected the servants with due care.²⁴ It has been argued that such diversion would be contrary to the intent of the donor of the funds and would discourage further donations for charitable purposes. The case was based upon the earlier English case of *Holliday vs. St. Leonard's*,²⁵ which in turn had rested upon dictum in *Duncan v. Findlater*.²⁶ Curiously, neither of these cases involved the tort liability of charitable institutions. Furthermore, the dictum of the *Duncan* case had been overruled in *Mersey Docks Trustees v. Gibbs*,²⁷ in the year 1866 and the *Holliday* case had been reversed in 1871 before the *McDonald* case by *Foreman v. Mayor of Canterbury*.²⁸ All of this prompted the Supreme Court of Washington to remark in *Pierce v. Yakima Valley Memorial Hospital*,²⁹ that when a court modifies an earlier decision it usually does so with the explanation that "the reason for the rule no longer exists," but that in regard to charitable im-

²³ 120 Mass. 432 (1876).

²⁴ Later Massachusetts case held no liability even if negligence in selection and retention of servants. *Roosen v. Peter Bent Brigham Hospital*, 235 Mass. 66, 126 N.E. 392 (1920).

²⁵ 11 C.B. N.S. 192 (1860).

²⁶ 7 English Reprint 934 (1839).

²⁷ 11 English Reprint 1500, 11 H. L. Cas. 686 (1866).

²⁸ 6 Q.B. 214 (1871).

²⁹ 43 Wash. 2d 162, 260 P. 2d 765 (1953).

munity the court should state that "the rule of immunity never did exist."

Soon after the *McDonald* case in Massachusetts, the Rhode Island court was faced with the question of whether or not a charitable hospital was liable for the negligent act of an intern. The court rejected immunity and held the hospital liable.³⁰ Following this decision the legislature enacted a statute granting immunity, thereby repudiating the *Glavin* decision. The statute is still in effect.³¹

DIFFERENT IMMUNITY THEORIES

The majority rule developed in the United States was to follow the lead of Massachusetts in holding charitable hospitals immune from liability in tort, but not all states reached the result on the trust fund theory.³² Several different theories were developed to support immunity. One group of decisions based the doctrine upon the argument that a patient in a charitable hospital impliedly waives his right to damages for injuries caused by negligence because he has accepted the benefits of the charity.³³ Most of these states have found a waiver even though the patient paid for the hospital services as he is still a beneficiary of the charity.³⁴ Another theory underlying immunity is that the doctrine of respondeat superior is not applicable to charities for the reason that vicarious liability is imposed only where the servant is employed to produce a profit for the master.³⁵ Still another argument has been that private charitable institutions are entitled to the same immunity as government inasmuch as both exist for the public benefit.³⁶ Finally, some courts have simply said that public policy dictates immunity.³⁷ Sometimes associated with this theory are the arguments that donors to charity would be discouraged from further donations if the charitable funds could be wiped out by one plaintiff via a substantial verdict and that it is better to sustain the charity which serves many people rather than hamper it by awarding damages to the small minority who may be injured. Perhaps it was a philosophy of public policy which prompted Chief Justice Folland of the Utah Supreme Court to remark in a dissenting opinion in *Sessions v. Thomas D. Dee Memorial Hospital Association*,³⁸ "It is better for a few individuals to suffer than that the whole community should be deprived of

³⁰ *Glavin v. Rhode Island Hospital*, 12 R.I. 411 (1879).

³¹ R.I. General Laws, §7-1-22 (1956).

³² For a leading case following the trust fund theory see: *Parks v. Northwestern University*, 218 Ill. 381, 75 N.E. 991 (1905).

³³ *Powers v. Massachusetts Homeopathic Hospital*, 109 F. 294, (1st Cir. 1901).

³⁴ *St. Vincent's Hospital v. Stine*, 195 Ind. 350, 144 N.E. 537 (1924); *Downs v. Harper Hospital*, 101 Mich. 505, 60 N.W. 42 (1894).

³⁵ *Hearns v. Waterbury Hospital*, 66 Conn. 98, 33 Atl. 595 (1895).

³⁶ *University of Louisville v. Hammock*, 127 Ky. 564, 106 S.W. 219 (1907).

³⁷ *Jensen v. Maine Eye and Ear Infirmary*, 107 Me. 408, 78 Atl. 898 (1910).

³⁸ 94 Utah 460, 78 P. 2d 645 (1938).

a much needed charitable institution." In that decision the majority of the court had refused to follow immunity.

It is apparent that the courts of the various states have been unable to agree on the theory of and the arguments in support of the charitable immunity doctrine. Historically, the cases indicate confusion, an indulgence in pure fiction, and several conflicting irreconcilable arguments. The several theories have each logically led to exceptions and modifications. These in turn have produced much conflict in the law from state to state and several results which appear to be unjustified.

It follows from the trust fund theory, for instance, that a negligently-injured plaintiff can recover from non-trust assets including the proceeds from liability insurance carried by the charity.³⁹ Thus, the ability of the plaintiff to recover is made dependent upon the existence of assets not a part of the trust. In effect, the charity is permitted to determine its obligation to compensate for its wrong via its voluntary acquisition of insurance or non-trust assets. Furthermore, the reason for acquisition of insurance and its function from the viewpoint of the insured is to shift a risk of financial loss and not to create a risk of loss or an obligation to pay. A legal obligation to pay should not depend upon the existence of insurance. Such a result, although theoretically logical with the trust fund theory of immunity, appears socially and economically unjustified.

Similarly, in Louisiana and Arkansas, it has been held pursuant to statute that the immunity of the insured hospital is not available as a defense by the insurer.⁴⁰ In Maryland the plaintiff may not bring suit directly against the insurer, as in Louisiana and Arkansas, but there is a statute which provides, in effect, that immunity is no defense when insurance coverage exists.⁴¹

A number of states have held that the charity is liable to employees, visitors, and strangers and immune only as to patient beneficiaries.⁴² This result appears consistent with the implied waiver theory of immunity and is contrary to the expected result under the trust fund theory. Furthermore, there has been a difference of opinion as to whether or not a paying patient is a beneficiary of the charity. A few jurisdictions have held that there is liability to the paying patient and

³⁹ *St. Luke's Hospital Association v. Long*, 125 Colo. 25, 240 P. 2d 917 (1952). *Moore v. Moyle*, 405 Ill. 555, 92 N.E. 2d 81 (1950); *Morton v. Savannah Hospital*, 148 Ga. 438, 96 S.E. 887 (1918); *Vanderbilt University v. Henderson*, 23 Tenn. App. 135, 127 S.W. 2d 284 (1938).

⁴⁰ *Stamos v. Standard Accident Insurance Co.*, 119 F. Supp. 245 (W.D. La. 1954); *McElroy v. Employers' Liability Assurance Corp. Ltd.*, 163 F. Supp. 193 (D. Ark. 1958) 8 Neg. Cases 2d 785; Ark. Stat. Ann. §66-517 (1957).

⁴¹ Md. Code Ann., Art. 48 A, §85 (1957).

⁴² *Cowans v. North Carolina Baptist Hospitals*, 197 N.C. 41, 147 S.E. 672 (1929) (Employee); *Cohen v. General Hospital Society of Connecticut*, 113 Conn. 188, 154 Atl. 435 (1931) (Stranger); *Hospital of St. Vincent of Paul v. Thompson*, 116 Va. 101, 81 S.E. 13 (1914) (Stranger).

have restricted immunity to the non-paying patient.⁴³ This is done on the theory that only the latter waives his right to damages. Such a distinction only magnifies the fiction of the implied waiver theory.

It is consistent with the trust fund theory to hold that there is immunity for both negligence of the hospital itself and for vicarious liability based upon respondeat superior. As noted previously, negligence of the hospital itself can be found in the furnishing of defective equipment, defects in buildings or grounds, or the lack of due care in the selection or retention of personnel. Accordingly, some courts have held that there is immunity on these facts.⁴⁴ In contrast, the inapplicability of respondeat superior theory of immunity leads inescapably to the conclusion that there is liability for corporate neglect. Thus, it has been frequently stated that the hospital will be liable for the furnishing of defective equipment or for negligence in the selection or retention of personnel even though it is immune from vicarious liability for the negligent acts of the employees themselves.⁴⁵

In view of the extreme divergence among the states regarding charitable immunity, the weaknesses in the underlying theories of the doctrine, and the questionable social and economic justification for the results produced, it is not surprising to be witnessing a judicial trend away from the rule. At the present time, more than one-quarter of the states hold that a charitable hospital is fully liable just as a for-profit enterprise would be.⁴⁶ Several of these reached the result of full liability by overruling prior decisions recognizing either total or qualified immunity and it is these states that indicate the trend.⁴⁷ At the other

⁴³ *Tucker v. Mobile Infirmary Association*, 191 Ala. 572, 68 So. 4 (1915) (Doubt re non-pay); *Wheat v. Idaho Falls Latter Day Saints Hospital*, 78 Idaho 60, 297 P. 2d 1041 (1956); *Mississippi Baptist Hospital v. Holmes*, 214 Miss. 906, 55 So. 2d 142 (1951) (Some doubt re non-pay); *Pierce v. Yakima Valley Memorial Hospital*, 43 Wash. 2d 162, 260 P. 2d 765 (1953); *Lyon v. Tumwater Evangelical Free Church*, 47 Wash. 2d 202, 287 P. 2d 128 (1955).

⁴⁴ *Roosen v. Peter Bent Brigham Hospital*, 235 Mass. 66, 126 N.E. 392 (1920) (No liability for negligent selection or retention of personnel); *Gregory v. Salem General Hospital*, 175 Ore. 464, 153 P. 2d 837 (1944) (No liability for negligent selection or retention of personnel); *Abston v. Waldon Academy*, 118 Tenn. 24, 102 S.W. 351 (1907) (No liability for failure to erect fire escapes as required by city ordinance).

⁴⁵ *Hearns v. Waterbury Hospital*, 66 Conn. 98, 33 Atl. 595 (1895); *Martino v. Grace - New Haven Community Hospital*, 146 Conn. 735, 148 A. 2d 259 (1959); *St. Vincent's Hospital v. Stine*, 195 Ind. 350, 144 N.E. 537 (1924); *Baptist Memorial Hospital v. McTighe*, 303 S.W. 2d 446 (Tex. Civ. App. 1957); *Medical and Surgical Memorial Hospital v. Cauthorn*, 229 S.W. 2d 932 (Tex. Civ. App. 1949) (Defective equipment); *Penaloza v. Baptist Memorial Hospital*, 304 S.W. 2d 203 (Tex. Civ. App. 1957); *Norfolk Protestant Hospital v. Plunkett*, 162 Va. 151, 173 S.E. 363 (1934); *Miller v. Sisters of St. Francis*, 5 Wash. 2d 204, 105 P. 2d 32 (1940) (Defective equipment); *Roberts v. Ohio Valley General Hospital*, 98 W. Va. 476, 127 S.E. 318 (1925).

⁴⁶ Alaska, Arizona, California, Delaware, Florida, Iowa, Minnesota, New Hampshire, New Jersey (recovery limited to \$10,000 by temporary statute), New York, Ohio, Utah, Vermont, and possibly North Dakota.

⁴⁷ *Ray v. Tuscon Medical Center*, 72 Ariz. 22, 230 P. 2d 220 (1951); *Malloy v. Fong*, 37 Cal. 2d 356, 232 P. 2d 241 (1951); *Haynes v. Presbyterian Hospital*,

extreme, slightly more than one-third of the jurisdictions appear to apply the rule of immunity to all patients.⁴⁸ The remaining states that have ruled on the question fall roughly into the category of drawing a distinction between paying and non-paying patients,⁴⁹ or the category of permitting recovery only from insurance or other non-trust assets or both.⁵⁰ Among the immunity states, however, as noted earlier, a significant number find liability to patients upon proof of failure to use due care in the selection or retention of employees or other form of negligence of the hospital itself, thus confining immunity to the negligent acts of servants and agents. Also, many find liability to strangers. Only a relatively small minority of the states follow the rule of total and complete immunity under all facts and circumstances.

Despite the trend noted in favor of charitable hospital liability, there is still in some jurisdictions strong support for immunity. In 1954, the Supreme Court of Kansas overruled immunity in the case of *Noel v. Menninger Foundation*⁵¹ and the legislature reacted with a statute effective April 1, 1959 reinstating immunity. The statute does not prevent the payment of a claimant from the proceeds of insurance. Connecticut, Maryland, Pennsylvania, and Virginia have recently reasserted the doctrine of immunity.⁵² Essentially, these courts have argued that to change the immunity rule, regardless of the merits of the question, would be judicial legislation and hence any change must come from the legislature. In so ruling, the Virginia court specifically conceded that the wisdom of the rule of immunity was debatable.

The most forceful arguments against charitable immunity are that it is "protected negligence," that it is inconsistent with sound social

241 Iowa 1269, 45 N.W. 2d 151 (1950); *Collopy v. Newark Eye and Ear Infirmary*, 27 N.J. 29, 141 A. 2d 276 (1958); *Bing v. Thunig*, 163 N.Y.S. 2d 3, 143 N.E. 2d 3 (1957); *Avellone v. St. John's Hospital*, 165 Ohio St. 467, 135 N.E. 2d 410 (1956).

⁴⁸ Connecticut, District of Columbia, Indiana, Kentucky, Maine, Massachusetts, Michigan, Missouri, Nebraska, North Carolina, Oregon, Pennsylvania, Rhode Island (statute), South Carolina, Texas, Virginia, West Virginia, Wisconsin, Wyoming. Lower court decisions in Michigan have overruled immunity and an appeal decision is awaited.

⁴⁹ Georgia, Idaho, Mississippi, Nevada, Washington, and perhaps Alabama. Idaho, Mississippi, and Washington have held the charitable hospital liable to the paying patient after prior decisions which indicated non-liability. Consequently, it is believed that these three states further evidence the trend away from immunity. For case citations, see note 32, *supra*. It would not be surprising to have these jurisdictions adopt a rule of full liability.

⁵⁰ Arkansas, Colorado, Georgia, Illinois, Kansas, Louisiana, Maryland, and Tennessee. The recent Illinois case of *Molitor v. Kaneland Community Unit District Number 302*, *supra* note 19, disapproves of this rule as applied to governmental immunity and appears to forecast an end to the rule as applied to charitable immunity.

⁵¹ 175 Kan. 751, 267 P. 2d 934 (1954).

⁵² *Martino v. Grace New Haven Community Hospital*, 146 Conn. 735, 148 A. 2d 259 (1959); *Cornelius v. Sinai Hospital of Baltimore*, 219 Md. 116, 148 A. 2d 567 (1959); *Knecht v. St. Mary's Hospital*, 392 Pa. 75, 140 A. 2d 30 (1958); *Memorial Hospital v. Oakes*, 200 Va. 878, 108 S.E. 2d 388 (1959).

policy which dictates that losses suffered by individuals through fault of another should be borne by all of society through insurance or similar loss distributive techniques, and that the rule produces the anomaly that a doer of good asks exemption from responsibility for its wrong even though all others must pay.⁵³ Fundamentally, the question is one of social policy and in spite of the recent decisions noted upholding immunity on the doctrine of *stare decisis* it may reasonably be anticipated that the doctrine will continue to be gradually eliminated from the law. It would not be surprising, however, to witness concurrently an effort by statute to place a ceiling on the dollar amount of damages recoverable by a plaintiff from a charitable hospital. Such a ceiling would serve to refute the argument in favor of immunity that a handsome judgment or two would destroy the charity's ability to serve society.

EMPLOYMENT RELATIONSHIP

Once the question of immunity has been disposed of where recovery is sought against the hospital for the negligent or wrongful act of a person working in the hospital, the issue then presented is whether or not the actor was the servant or the agent of the hospital at the time of the injury-producing incident. An employment relationship may be, as a general matter of law, whether in a hospital or elsewhere, that of principal-agent, master-servant, or employer-independent contractor. The doctrine of respondeat superior holds the principal liable to a third party injured by the tortious act of the agent and the master liable for the tortious act of his servant committed while furthering the principal's or master's business. On the other hand, the employer is not liable for a negligent or wrongful-acting independent contractor unless the work being done by the latter is deemed to be inherently dangerous⁵⁴ or unless there is some compelling reason of public policy to impose vicarious liability on the employer.⁵⁵ The liability or non-liability of a hospital has traditionally been dependent upon identifying the actor as an agent, a servant, or an independent contractor. This identification is frequently difficult in the perspective of highly developed and complicated medical procedures.

Properly speaking an agent is defined as one who represents his principal in business dealings or contractual negotiations with third parties. The very purpose of agency is to bind the principal and the third party in contract. In contrast, a servant performs manual or

⁵³ *President and Directors of Georgetown College v. Hughes*, 130 Fed. 2d 810 (D.D.C. 1942).

⁵⁴ *Cage, et al., v. Creed*, 308 S.W. 2d 78 (Tex. 1957), illustrates the inherently dangerous exception to the general rule. Excavation in public highway is an inherently dangerous activity and the employer is liable for the negligence of the excavator.

⁵⁵ *Adams v. F. W. Woolworth Co.*, 144 Misc. 27, 257 N.Y.S. 776 (1932). Employer liable for tort of detective agency, an independent contractor.

mechanical acts for his master under the latter's direction and control. The servant does not deal with third parties for the purpose of binding his employer in contract. In speaking of the master-servant relationship, the Kentucky court in *American Savings Life Insurance Co. v. Riplinger*,⁵⁶ said, "A servant is a person subject to the command of his master as to the manner in which he shall do his work and the master is the one who not only prescribes the work but directs, or may direct, the manner of doing the work." In actual practice courts frequently use the terms "agent" and "servant" interchangeably.

INDEPENDENT CONTRACTORS

An independent contractor is "one who exercises some independent calling, occupation, or employment, in the course of which he undertakes, supplying his own materials, servants, and equipment, to accomplish a certain result, not being subject while doing so to the direction and control of his employer, but being responsible to his employer for the end to be achieved, and not for the means by which he accomplished it."⁵⁷

The Iowa court in *Burns v. Eno*,⁵⁸ listed the tests of an independent contractor as follows: "The commonly recognized tests of such a relationship are, although not necessarily concurrent or each in itself controlling: (1) the existence of a contract for the performance by a person of a certain piece or kind of work at a fixed price; (2) independent nature of his business or of his distinct calling; (3) his employment of assistants with the right to supervise their activities; (4) his obligation to furnish necessary tools, supplies, and materials; (5) his right to control the progress of the work, except as to final results; (6) the time for which the workman is employed; (7) the method of payment, whether by time or job; (8) whether the work is part of the regular business of the employer."

It is to be noted that the above quotation emphasizes that the factors listed are not necessarily concurrent or each in itself determinative. However, the key test for distinguishing between a servant and an independent contractor is frequently that of control. A servant is subject to his master's right of control in regard to both the means and methods of doing the work and also in regard to final result whereas an independent contractor is subject to the employer's right of control only in regard to final result. This is the basis for the rule that an employer is not liable for the tortious conduct of an independent contractor as it is thought that no vicarious liability should exist if there is no right to control the workman's activities.

It is clear that where immunity is not applicable, a hospital is liable

⁵⁶ 249 Ky. 8, 60 S.W. 2d 115 (1933).

⁵⁷ Mechem, Agency, p. 13, §20 (3rd ed. 1923).

⁵⁸ 213 Iowa 881, 240 N.W. 209 (1932).

under the doctrine of respondeat superior for the negligence of a non-professional employee. In *Ray v. Tucson Medical Center*,⁵⁹ the patient was injured when thrown to the ground after a nurse's aide lost control of a four-wheel stretcher being used to convey the patient to the hospital's physiotherapy department. A master-servant relationship existed between the hospital and the nurse's aide as the former possessed the right to control the latter's work. Hence the hospital was vicariously liable for her negligence.⁶⁰

At the other extreme of hospital employment relationships, it has been the general rule that a fully licensed and practicing physician who simply has hospital medical or surgical staff privileges is an independent contractor and not a servant or an agent of the hospital. The mere fact that a professional person is on the staff of a medical care institution does not result in a finding that he is a servant. A recent leading case is *Mayers v. Litow, et al.*,⁶¹ where Dr. Litow, a staff physician of Midway Hospital, advised the patient to undergo surgery. He was assisted during the surgical procedure by another staff doctor. A severed nerve resulted in a paralyzed vocal cord. The patient was not successful in a suit against the hospital. The court said that normally the question of agency is one of fact for the jury, but that here this could not be so because there was no evidence at all that the doctors were servants of the hospital. They were simply medical staff men who used the hospital facilities to perform the surgery. The court stressed that the contract for medical treatment was between the patient and Dr. Litow; that the hospital had no right to control the doctors' acts; that the doctors were not paid by the hospital; that the plaintiff had made his own financial arrangements directly with the hospital for his institutional care; and that the surgeon had never done anything nor said anything permitting the plaintiff to infer that he was the hospital's servant.

The same result has been reached even though the staff doctor is an officer and/or or a principal shareholder of the hospital corporation.⁶² These courts emphasize that there is a distinction between the managerial and medical activities of the physician. As to the latter he acts as an independent contractor. The hospital corporation is entirely separate from its managers and stockholders.

The emphasis in the reasoning of *Iterman, et al., v. Baker*,⁶³ in

⁵⁹ 72 Ariz. 22, 230 P. 2d 220 (1951).

⁶⁰ Similarly, charity hospital liable to one not a patient for negligence of hospital elevator operator. *Sisters of Charity of Cincinnati v. Duvelius*, 123 Ohio St. 52, 173 N.E. 737 (1930).

⁶¹ 154 Cal. App. 2d 413, 316 P. 2d 351 (1957).

⁶² *Barfield v. South Highland Infirmary, et al.*, 191 Ala. 553, 68 So. 30 (1915); *Black v. Fischer, et al.*, 30 Ga. App. 109, 117 S.E. 103 (1923); *Stacy v. Williams*, 253 Ky. 353, 69 S.W. 2d 697 (1934).

⁶³ 214 Ind. 308, 15 N.E. 2d 365 (1938).

reaching the same result of the hospital's non-liability for the negligent act of a physician was that a corporation may not practice medicine either directly or indirectly by employing licensed physicians. A doctor may not, the court argued, accept directions regarding his medical work from an unlicensed corporation and, hence, the doctors must be independent contractors. The hospital's contract with the patient is only to furnish medical services to be rendered by others and it does not undertake to practice medicine through servants. It is liable only if it negligently selects physicians to treat the patient. This case represents a strict application of the corporate practice rule and the same reasoning is recognized elsewhere but certainly not universally.⁶⁴

The holding that a technically-trained professional person is an independent contractor is not confined to licensed physicians. *Runyan v. Goodrum*⁶⁵ held that an x-ray technician was an independent contractor for the reason that she possessed peculiar knowledge and acted pursuant to her own initiative and discretion without direction from her employer, a private hospital owned and operated by physicians.

One of the factors stressed by the California court in *Mayers v. Litow*⁶⁶ was the fact that the surgeons were not paid by the hospital. Theoretically, the payment of a salary to a staff physician, where the same is permitted under the corporate practice rule or done by the hospital in spite of legal rule, should not change the result that he is an independent contractor. Salary does not necessarily mean the hospital has a right to control a professional person's activities and hence it is not necessarily inconsistent with an employer-independent contractor relationship.

Nevertheless, some cases have held that the payment of a salary to a staff physician or other professionally-trained person renders the doctrine of respondeat superior applicable so that the hospital becomes vicariously liable for the negligence of the recipient of the salary. In *Gilstrap v. Osteopathic Hospital*,⁶⁷ the hospital was liable for the malpractice of a staff surgeon committed during a tonsil operation. The court simply held that a salary, which remained the same regardless of the number of patients treated by the doctor, negated the hospital's defense that the negligent actor was an independent contractor. Similar results are found elsewhere.⁶⁸ Most of the cases so ruling seem to involve a for-profit hospital.

These courts, in effect, are holding that a hospital does more than

⁶⁴ A similar case is *Rosane v. Senger, et al.*, 112 Colo. 363, 149 P. 2d 372 (1944).

⁶⁵ 147 Ark. 481, 228 S.W. 397 (1921).

⁶⁶ *Supra* note 61.

⁶⁷ 224 Mo. App. 24 S.W. 2d 249 (1929).

⁶⁸ *Brown v. La Societe Francaise de Bienfaisance Mutuelle*, 138 Cal. 475, 71 Pac. 516 (1903); *Brant v. Sweet Clinic, et al.*, 167 Wash. 166, 8 P. 2d. 972 (1932); *Vaughn v. Memorial Hospital*, 100 W. Va. 290, 130 S.E. 481 (1925); *Treptan, et al., v. Behrens Spa, Inc.*, 247 Wis. 438, 20 N.W. 2d 108 (1945).

contract with the patient to furnish medical services to be rendered by others. Rather they are saying that the hospital contracts to treat the patient and are rejecting the argument of *Itermann et al., v. Baker*⁶⁹ that a corporation is prohibited from practicing medicine. The hospital can render medical treatment only through servants and the employment of a physician on salary makes him a servant. They have ignored the fact that the hospital has no actual control and probably no right to control the professional activities of the salaried physician. It can well be argued that these cases represent a misapplication of the traditional concepts of the doctrine of respondeat superior. However, the moral from the hospital's point of view would be to avoid the payment of a salary to a staff physician.

When a hospital expressly contracts to perform medical services, which is not the usual situation, then it is liable for the negligence of physicians employed by it to discharge the contractual undertaking with the patient. For instance, in *Guisti v. C. H. Weston Co., et al.*,⁷⁰ the defendant hospital association had entered a contract with a high school to provide medical care to members of the school's football squad. The defendant's doctors were paid a salary and furnished office space. The court held the defendant vicariously liable rejecting the argument that the negligent doctors were independent contractors. It said that the test of the right to exercise control as to the manner and the details of the doctor's work must give way to the rule that when one is bound to perform a duty by contract he can't absolve himself by devolution of the contractual duty upon a stranger or an independent contractor.⁷¹ Thus, the legal relationship between the hospital and the the doctors was that of master-servant and respondeat superior is applicable.

By legal definition, the applicability of the doctrine of respondeat superior depends upon the relationship in fact between the employer and the negligent actor who acts while furthering the former's business. Applicability is not, as a general rule and in the absence of special circumstances dependent upon the relationship between the employer and the injured third party or upon what the third party thinks the employment relationship to be. If X should drive Y's truck with permission on an errand of his own and in the process negligently

⁶⁹ *Supra* note 63.

⁷⁰ 165 Ore. 525, 108 P. 2d 1010 (1940).

⁷¹ Compare: *Holland v. Eugene Hospital*, 127 Ore. 256, 270 P. 784 (1928). (Where the hospital had not expressly contracted to treat the patient the court followed the general rule that a staff physician is an independent contractor and hence the hospital is not vicariously liable.) Accord: *Jenkins v. Charleston General Hospital*, 90 W. Va. 230, 110 S.E. 560 (1922). (A private for-profit hospital had contracted with patient's employer to render medical treatment to employees. Hospital liable for act of radiologist employed and paid by it to carry out hospital's contract.)

injure P, then P could not, in the absence of an automobile ownership statute, hold Y liable in damages for X's negligent act. It generally would not make any difference legally if the truck had Y's name painted on the side, leading P to reasonably believe that it was Y or Y's servant who was driving.

Nevertheless, in some cases possible vicarious liability for the negligence of a physician or other professional person has been founded upon acts of the defendant hospital which cause the patient to reasonably believe that the physician is the servant of the institution when in fact he is not under the control of defendant or perhaps not even employed by the hospital at all. This is the theory of "ostensible agency." It ignores both the test of control and the payment of a salary as determinative of vicarious liability. Furthermore, it ignores the fact that the negligent actor may be acting in the furtherance of his own business rather than the hospital's.

In *Stanhope v. Los Angeles College of Chiropractic*,⁷² the plaintiff was taken to the defendant hospital after suffering a broken back in an accident. He was examined by a Dr. Metzinger who told the plaintiff that no bones were broken but that x-ray pictures should be taken. The patient was removed to the x-ray laboratory, which was under the complete control of a Dr. Joyant. It was shown that markings on the door read "Los Angeles X-ray Laboratory"; that Dr. Joyant collected his own fees and none went to the hospital corporation; that the hospital did not dictate rules to Dr. Joyant nor the hours during which the laboratory was open for business; that he did work on the hospital patients and that he taught the hospital's students; that the laboratory equipment was owned personally by the president and a director of the hospital corporation; that it was located in space owned by the hospital but that Dr. Joyant did not pay rent. Dr. Joyant took only an anterior-posterior x-ray, which was negative, and the plaintiff was successful in establishing by expert medical testimony that it was accepted medical practice in the community to take both lateral and anterior-posterior pictures. Hence Dr. Joyant was guilty of malpractice. The hospital, of course, denied that Dr. Joyant was its agent or its servant. In the lower court, there was a trial to a jury which returned a verdict for the plaintiff against both Joyant and the hospital. The appellate court affirmed saying that the agency is ostensible when the principal intentionally or by want of ordinary care causes a third party to reasonably believe that another is his agent or servant who is not really employed by him. It was clear, the court said, that a patient in pain has no duty to inquire whether doctors are employees or independent contractors. The court concluded that ostensible agency is a question of fact for the jury and on the facts of this case the evidence was suffi-

⁷² 54 Cal. App. 2d 141, 128 P. 2d 705 (1942).

cient to support the jury's finding that Dr. Joyant was an agent or servant of the hospital corporation.

To like effect is the leading case of *Seneris v. Haas*,⁷³ which held that a prima facie case was established against the hospital and that the issue of a master-servant relationship should be decided by the jury where a negligent anesthesiologist was one of six such physicians on the hospital's staff who had regular "on call" rotating duty. The evidence further indicated that the doctor himself billed the patient for his professional services but that he had been called to attend the patient by a hospital nurse and that he did not work elsewhere. In *Brown v. Moore, et al.*,⁷⁴ partners in a private for-profit sanitarium were held liable for the professional malpractice of a neuro-psychiatrist named Dr. Kelly whom they employed on salary as the medical director of the sanitarium. Dr. Kelly was not a partner and the evidence indicated that the defendants had no control over his professional activities. The court reasoned that under the circumstances of employment on salary it did not believe the doctor to be an independent contractor. Significantly, however, the court went on to say that even if it assumed that Dr. Kelly was an independent contractor as to the defendants still they were liable for his act because they held out and represented to the patient and to the public that medical treatment was to be given in the sanitarium by doctors employed therein. Hence, regardless of the doctor's relationship to the defendants, he is deemed to be their servant as to the patient making the doctrine of respondeat superior applicable.

In effect, these ostensible agency cases are ruling that the "holding out" of the physician as a servant, when in fact he is not, estops the defendant hospital from asserting the true relationship as a defense to the imposition of vicarious liability. It is true that in each of these cases the hospital has been the one who selected or supplied the doctor for the patient. Traditionally, however, this has not been and should not be recognized as enough standing alone to impose vicarious liability. Certainly, a physician, a hospital, or a private individual who supplies or recommends a physician to a patient has not been nor should he be liable for the latter's malpractice unless they are partners or unless there is negligence in the recommendation.⁷⁵ Nevertheless, the ostensible agency cases are different on their facts from a mere recommendation and perhaps the results are justified as a matter of social policy when the patient has justifiable grounds for believing that the defendant is the responsible party. However, the theory greatly expands possible hospital liability and care should be exercised by the courts to confine the theory's use to factual situations where there is a true

⁷³ 45 Cal. 2d 811, 291 P. 2d 915 (1955).

⁷⁴ 247 F. 2d 711 (3rd Cir. 1957).

⁷⁵ Annot., 46 ALR 1455; *Mayer v. Hipke*, 183 Wis. 382, 197 N.W. 333 (1924).

"holding out" and a misrepresentation to the patient. It is noted that these courts have reached the same result by frankly admitting that due to the lack of hospital control the physician was an independent contractor but that, nevertheless, the hospital was liable because the medical treatment involved inherently dangerous activities. Such reasoning would be consistent with the generally recognized exception in the commercial world to the basic doctrine that an employer is not liable for the negligence of an independent contractor. However, an application of the inherently dangerous activity exception to the medical field is questionable and would open the door even wider to possible hospital liability for the acts of the professional staff.⁷⁶

Resident physicians are licensed to practice medicine but are still in training perfecting a specialty. Interns are medical school graduates working in the hospital prior to licensure as a part of their formal medical education. An employment contract arises between the resident or intern and the hospital at the time of appointment by the institution. As a part of the contract the hospital agrees to compensate these professional people either in the form of a salary or by furnishing living accommodations or both. The resident and the intern do from time to time diagnose illness and render medical treatment to patients under proper supervision of the hospital's director of medical education or the chief of medical or surgical services. Generally the patient has no freedom in selecting the resident or intern who cares for him.

Under these circumstances the cases are clear that the doctrine of respondeat superior applies rendering the hospital vicariously liable for the negligent acts of residents and interns occurring within their routine hospital functions. It is said that the facts negative an employer-independent contractor relationship and this is so even if the negligence occurs during the performance of a professional act. A professional act may be a "routine hospital function" of a resident physician or intern. The majority of the cases do not speak in terms of the hospital's right to control the means and methods of the resident's or intern's activities, but rather simply rule that they are employees of the hospital making respondeat superior applicable.⁷⁷

⁷⁶ This ostensible agency theory of vicarious liability in the hospital cases is not without parallel in commercial enterprise. When a department store leases a given department to an independent operator and then holds itself out as the owner or the one in control of the lessee's business the store is vicariously liable for the negligence of the lessee. *Augusta Friedman's Shop v. Yeates*, 216 Ala. 434, 113 So. 299 (1927). (Store liable for negligence of beauty shop lessee); *Santise v. Martins, Inc.*, 258 N.Y. App. 663, 17 N.Y.S. 2d 741 (1940); *Hannon v. Siegel-Cooper Co.*, 167 N.Y. 244, 60 N.E. 597 (1901); *Combs v. Kobacker Stores*, 114 N.E. 2d 447, (Ohio App. 1953).

⁷⁷ *Bowers v. Olch, et al.*, 120 Cal. App. 2d 108, 260 P. 2d 997 (1953) (Hospital liable for act of resident surgeon when needle left in abdomen during surgery). *Sepaugh v. Methodist Hospital*, 30 Tenn. App. 25, 202 S.W. 2d 985 (1946) (Hospital liable for act of intern who negligently administered hypodermoclysis injection. Dissent maintained that said injection required technical skill

A regular duty hospital nurse, by the great weight of authority, has been considered a servant of the hospital and, hence, where an immunity doctrine is not applicable the hospital is liable under the doctrine of respondeat superior for her negligent act or omission committed within the scope of her normal and usual employment duties even though the act may be of a professional nature. The negligence of the nurse is established by proof that she ought to have known or foreseen that injury or damage to the patient would be the result of her conduct.⁷⁸ In addition to the hospital's vicarious liability the nurse herself is always personally liable.

Respondeat superior was applied where a nurse administered a hypodermic injection with an unsterile instrument without first wiping the skin with an alcoholic sponge;⁷⁹ where nurse left a hot water bottle in bed burning the patient;⁸⁰ where nurse continued hypodermoclysis injection after noticing that tissues were not properly absorbing;⁸¹ where nurse supervisor permitted student nurse to have keys to medicine room to prepare codeine injection ordered by patient's doctor and student nurse prepared morphine by mistake resulting in patient's death;⁸² where nurse failed to use care in lowering bed;⁸³ where nurse administered scalding hot enema;⁸⁴ and where nurse placed tray containing teapot with hot water on table beside bed of drowsy surgical patient under drugs and left unattended with the result that the water fell burning the patient.⁸⁵

A nurse's negligence may be found in an omission, a failure to act or inattentive care as well as in an affirmative act. In the recent case of *Hendricks v. Sanford*,⁸⁶ it was held to be a question for the jury

with the hospital neither reserving nor exercising any right to control hence rendering respondeat superior inapplicable). *Moeller v. Hauser and Finkelnberg*, *Moeller v. Lofquist, et al.*, 237 Minn. 268, 54 N.W. 2d 639 (1952) (Hospital liable for resident's negligent care of a patient in traction). *City of Miami v. Rosa Oates*, 152 Fla. 21, 10 So. 2d 721 (1942) (Hospital liable for intern's negligence in preparing patient for cauterization of old surgical incision). *Waynick v. Reardon and Duke University, Inc.*, 236 N.C. 117, 72 S.E. 2d 4 (1952) (Hospital liable when resident surgeon punctured blood vessel during surgery on ward patient who was given no choice of doctors). *Andrews v. Youngstown Osteopathic Hospital Association*, 77 Ohio App. 35, 147 N.E. 2d 645 (1956) (Serum sickness resulting from intern's injection of tetanus injection). *Carver Chiropractic College v. Armstrong*, 103 Okla. 123, 229 Pac. 641 (1924) (Intern broke patient's ribs). *Stuart Circle Hospital Corporation v. Curry*, 173 Va. 136, 3 S.E. 2d 153 (1939) (Hospital liable when intern injected pre-x-ray dye solution into tissues).

⁷⁸ 35 Am. Jur. *Master and Servant* §587 (1941).

⁷⁹ *Kalmus v. Cedars of Lebanon Hospital*, 132 Cal. App. 2d 243, 281 P. 2d 872 (1955).

⁸⁰ *Pensacola Sanitarium v. Wilkins*, 68 Fla. 447, 67 So. 124 (1914).

⁸¹ *Parish v. Clark*, 107 Fla. 598, 145 So. 848 (1933).

⁸² *Sessions v. Thomas D. Dee Memorial Hospital Ass'n.*, 94 Utah 460, 78 P. 2d 645 (1938).

⁸³ *Welsh v. Mercy Hospital*, 65 Cal. App. 2d 473, 151 P. 2d 17 (1944).

⁸⁴ *City of Shawnee v. Roush*, 101 Okla. 60, 223 Pac. 354 (1924).

⁸⁵ *Rice v. California Lutheran Hospital*, 27 Cal. 2d 296, 163 P. 2d 860 (1945).

⁸⁶ 216 Ore. 149, 337 P. 2d 974 (1959).

as to whether it was negligence to fail to turn the patient in bed regularly or at all in a situation where the patient developed bed sores. In another instance, it was held to be error when the lower court directed a nonsuit in *Thomas v. Seaside Memorial Hospital*⁸⁷ on the following facts. An eight-month-old baby had undergone minor surgery; the patient was still under ether and unconscious when returned to the nursery. The baby's mother was ordered by a nurse to leave the nursery while other patients were bathed. The nurse herself left the room and the only hospital attendant remaining in the nursery was a nurse's aide changing bed clothing. During this interval the baby suffered a clot which collapsed a lung causing death. There was expert testimony to the effect that had a trained person been watching the unconscious infant she might have been able to recognize symptoms and consequently been in a position to render aid saving the life. There are other cases relating to a nurse's failure to act or inattentive care.⁸⁸

One of the most recent cases involving a nurse's failure to act is *Goff vs. Doctors General Hospital of San Jose*.⁸⁹ The patient's physician had made an incision to facilitate childbirth; he failed to suture it. This act was conceded to be negligence rendering the doctor liable for malpractice. Suit was also brought against the hospital and two nurses on the allegations that the latter were negligent in failing to check the patient's pulse, blood pressure, temperature, and respiration; in failing to call the doctor when first aware that bleeding was above normal because the nurses doubted that the doctor would come to the hospital; and, finally, in failing to notify the hospital administrative authorities that they were "horrificed" at the treatment that the doctor

⁸⁷ 80 Cal. App. 2d 841, 183 P. 2d 288 (1947).

⁸⁸ *Tulsa Hospital Association v. Juby*, 73 Okla. 243, 175 Pac. 519 (1918). (Failure of nurse to change bed clothing for two hours after discovery that patient was wet from leaking roof; said failure caused pneumonia. Hospital liable.) *Wetzel v. Omaha Maternity and General Hospital Association*, 96 Nebr. 636, 148 N.W. 582 (1914). (Absence of nurse from room of delirious patient for five minutes may amount to negligence.) *Skidmore v. Oklahoma Hospital*, 137 Okla. 133, 278 Pac. 334 (1929). (Nurse waited for 22 hours and failed to call doctor after patient repeatedly requested catheterization.) *Williams v. Pomona Valley Hospital Association*, 21 Cal. App. 359, 131 Pac. 888 (1913). (Failure of nurse to exercise continuous care and to follow up after placing hot water bottles on feet of unconscious patient.) *Birmingham Baptist Hospital v. Branton*, 218 Ala. 464, 118 So. 741 (1928). (Hospital liable when nurse left expectant mother unattended and did not call doctor in time to deliver child. Whether in fact the child was stillborn or died soon after birth due to lack of attention held question for jury.) *Sherman v. Hartman, et al.*, 137 Cal. App. 2d 589, 290 P. 2d 894 (1955). (Surgical patient returned to hospital room and during blood transfusion needle came out of vein causing blood to enter tissue. Nurse had left patient to go to lunch leaving a male orderly to watch patient. Res ipsa loquitur applied and respondeat superior renders hospital liable.) *Valentin v. La Societe Francaise de Bienfaisance Mutuelle*, 76 Cal. App. 2d 1, 172 P. 2d 359 (1946). (Nurse permitted patient to go for three days without calling doctor after becoming aware of patient's deteriorating condition.)

⁸⁹ 166 Cal. App. 2d 314, 333 P. 2d 29 (1958).

was rendering. After judgment for the hospital and the nurses, the trial judge granted plaintiff's motion for a new trial. The appellate court affirmed, saying that the omissions by the nurses were sufficient evidence to support a finding of negligence and a consequent liability of the hospital on respondeat superior. There was expert testimony to the effect that the nurses' care was not commensurate with the skill ordinarily used by nurses in good standing in the community. He further testified that the nurses should have called the patient's attending physician sooner; should have notified their hospital administrative superior; that time was of the essence and that if proper care had been summoned sooner the chance of saving the patient's life would have been greater. The nurses' duty to call their hospital administrative superior when they knew that the attending physician was not caring properly for the patient raises important implications. Apparently, it would put the hospital in the position of attempting to remove the case from the hands of a private physician employed by the patient and who was not an employee of the hospital.

The fact that the nurse's negligence occurs while acting pursuant to the orders of the patient's physician does not insulate the hospital from liability. For instance, the doctor in *Rice v. Lutheran Hospital*, supra, had prescribed that the patient be served tea. However, this does not make the nurse who served the tea the servant of the doctor and shift the vicarious liability for her negligence to him for the reason that the doctor, even though he had ordered the tea, was not supervising and controlling the serving. The hospital still had the right to direct and control the nurse's act and hence the nurse was still the servant of the hospital.⁹⁰ On such facts the borrowed servant rule does not apply.

Under the borrowed servant rule a hospital nurse, an intern, or other person generally in the employ of the hospital may temporarily become a servant of another with the result that the hospital as general employer is insulated from vicarious liability for the negligent act of the borrowed servant occurring while he or she is employed by the other. This is illustrated by the Vermont case of *Minogue v. Rutland Hospital, Inc.*⁹¹ The patient was admitted to the defendant hospital for childbirth and was under the care of her own private physician who was not an employee of the hospital. During the delivery the doctor was assisted by a hospital nurse employed and paid by the defendant. He directed her to apply pressure to the sides of the patient and during

⁹⁰ *Swigerd v. City of Ortonville, et al.*, 246 Minn. 339, 75 N.W. 2d 217 (1956). (Hospital liable for nurse's negligence in rendering heat treatments even though said treatments ordered by physician for the reason that the physician was not giving and not expected to give direct personal supervision to the nurse in the carrying out of his prescribed treatment).

⁹¹ 119 Vt. 336, 125 A. 2d 796 (1956).

this act the patient's ribs were broken. The patient had paid a fee to the hospital for the use of the obstetrical department, the delivery room, and the nurses in attendance there. The court held that a directed verdict in favor of the hospital should have been given because in this instance the hospital is not liable for the negligent act of the nurse for the reason that at the time of the specific transaction in question she was acting under the control of the doctor and not the hospital.

The rule is frequently applicable in surgical situations. The patient in *Saint Paul-Mercury Indemnity Co. v. St. Joseph's Hospital*⁹² had been admitted to the defendant hospital for an appendicitis operation to be done by a surgeon of her own selection and employment. During the surgery he was assisted by four nurses all of whom were generally employed by the hospital. The surgeon called for some "warm water"; one of the nurses obtained some water, but it was deemed to be too hot; she brought more water, the doctor tested it with his finger, and following the testing either he or the nurse poured it into the surgical wound with the result that the patient was burned. The surgeon himself was admittedly negligent; the plaintiff is his liability insurance carrier who brings suit against the hospital after settlement with the patient alleging that the defendant is jointly liable with the doctor for the negligence of its employee, the nurse. The jury gave a verdict for the plaintiff but the granting of defendant's motion for judgment notwithstanding the verdict is now affirmed. The court held that the hospital could not be jointly liable because the servant's negligence occurred at a time when she was working under the exclusive direction and control of the surgeon. It said,

The rule is plain that when a general employer assigns his servant to duty for another and surrenders to the other direction and control in relation to the work to be done, the servant becomes the servant of the other insofar as his services relate to the work so controlled and directed. His general employer is no longer liable for the servant's torts committed in the directed and controlled work. In the operating room the surgeon must be the master. He can't tolerate any other voice in the control of his assistant.⁹³

⁹² 212 Minn. 558, 4 N.W. 2d 637 (1942).

⁹³ *Id.* at 639. See also *Randolph v. Oklahoma City General Hospital*, 180 Okla. 513, 71 P. 2d 607 (1937). (Defendant hospital not liable for negligence of nurse occurring shortly after surgical operation during period of time when patient's private physician retained immediate supervision over care being rendered patient.) *Beadles v. Metayka, Metayka v. Bowles, et al.*, 135 Colo. 366, 311 P. 2d 711 (1957). (Hospital not liable when momentarily unattended surgical patient fell to floor after patient's private surgeon had entered operating room and assumed command of nurses and hospital orderly assisting him). *Hull v. Enid General Hospital Foundation*, 194 Okla. 446, 152 P. 2d 693 (1944). (Hospital not liable for negligence of salaried x-ray technicians while administering x-ray treatments under control and direction of patient's private physician).

Whenever the facts indicate that different inferences could be drawn as to the identity of the controlling master of an allegedly borrowed servant at the time of the negligent act then it is a question for the jury. When a hospital intern, in the general employ of the hospital, assisted a surgeon in the performance of a Caesarean section and the intern applied excessive silver nitrate to the eyes of the newborn infant the jury was justified in finding that the intern was the servant of the surgeon.⁹⁴

When the borrowed servant rule operates to insulate the hospital from liability, it necessarily logically follows that the temporary master of the loaned employee is vicariously liable for the latter's negligent act. In *McConnell v. Williams*,⁹⁵ the surgeon was liable for the intern's act as it was found that he had complete control of the operating room and everyone in it at the time of the negligence although there was no claim nor evidence that the surgeon was himself negligent.⁹⁶

Cases of this nature are to be distinguished from cases where the negligence has occurred in pre-surgical preparation such as the cleaning of the operating room, the preparation of sterile drapes or the sterilization of instruments. Here the acts are done by nurses or others in their capacity as general servants of the hospital before the surgeon has assumed command. Similarly, the surgeon is not vicariously liable for negligent acts of others occurring in the routine post-operative care of the patient which he is not personally supervising and directing. In *Hallinan v. Prindle*,⁹⁷ the hospital was liable and the surgeon exonerated when a nurse during the course of pre-surgical preparation failed to read the bottle label and by mistake supplied a solution of 4 per cent formalin rather than 1 per cent novocain.

Furthermore, in spite of the quoted language from *Saint Paul-Mercury Indemnity Co. v. St. Joseph's Hospital*,⁹⁸ and the other cited cases, the surgeon is not always the master of surgical participants and is not always vicariously responsible for another's negligence in the operating room.⁹⁹ In several sponge count cases it has been held that

⁹⁴ *McConnell v. Williams*, 361 Pa. 355, 65 A. 2d 243 (1949).

⁹⁵ *Ibid.*

⁹⁶ Accord: *Benedict v. Bondi*, 384 Pa. 574, 122 A. 2d 209 (1956). (Surgeon liable for negligence of operating room nurse in the preparation and application of hot water bottles during surgery). *Hull v. Enid General Hospital Foundation*, 194 Okla. 446, 152 P. 2d 693 (1944). (Physician liable for negligence of hospital x-ray technicians administering treatments under his control and direction). *Beadles v. Metayka*, *Metayka v. Bowles, et al.*, 135 Colo. 366, 311 P. 2d 711 (1957). (Surgeon liable for negligence of orderly or nurse when momentarily unattended patient fell to floor). *Aderhold v. Bishop*, 94 Okla. 203, 221 Pac. 752 (1923). (Surgeon liable for negligence of hospital nurse assisting him during operation when patient burned by pan of hot water left by nurse at feet of patient).

⁹⁷ 220 Cal. 46, 29 P. 2d 202 (1934).

⁹⁸ *Supra* note 92.

⁹⁹ Annot. 60 ALR 147 (1929).

the surgeon is not liable under respondeat superior for an erroneous sponge count by a nurse for the reason that while making the count she is the servant of the hospital and not the surgeon.¹⁰⁰ The hospital is liable.¹⁰¹ However, the surgeon may be deemed by some courts to be personally negligent if a miscount of sponges occurs during surgery as he is not entitled to rely on the nurse's count.¹⁰² In all of these cases the failure to properly count the sponges resulted in the foreign object being left in the patient's body.

As a general conclusion it can be said that the facts surrounding the selection and control of the several participants are determinative of the applicability of the doctrine of respondeat superior in surgical cases where there has been negligence of one or more of the participants resulting in injury to the patient. In *Thompson v. Lillehei*¹⁰³ the defendants were the University of Minnesota Hospital and six doctors. The plaintiff was serving as a blood donor for her daughter who was about to undergo delicate heart surgery. Both the daughter and the plaintiff were anesthetized and placed on adjoining tables in the operating room. The anesthetist, at the plaintiff's table, permitted a bottle of glucose to become empty, causing an air embolism which resulted in permanent disability to the plaintiff. This anesthetist was a licensed physician. He was not a defendant in the suit. Plaintiff had no evidence that the doctor defendants were individually negligent and his case was based upon the argument that the hospital and other participants in the surgery were vicariously liable for the negligent act of the anesthetist. The suit was dismissed against the hospital on the basis of governmental immunity. It was further held that the head surgeon in charge was not vicariously liable since he had no power to direct and control the activities of the anesthetist. Each had a separate role to play in the surgery and each role required individual attention. The anesthetist was exercising his own independent medical knowledge without specific directions from the head surgeon. All of the physician participants were salaried members of the University of Minnesota Medical School and had been assigned to this operation by the head of the surgery department. In view of these facts it might be speculated whether or not the hospital would have been liable for the anesthetist's act if immunity had not been applicable. The court was not faced with this issue.

¹⁰⁰ *Funk v. Bonham*, 151 N.E. 22 (Ind. App. 1926), *Guell v. Tenney*, 262 Mass. 54, 159 N.E. 451 (1928). *Baker v. Wentworth*, 155 Mass. 338, 29 N.E. 589 (1892). *Niebel v. Winslow*, 88 N.J.L. 191, 95 Atl. 995 (1915).

¹⁰¹ *Rural Education Association v. Bush*, 298 S.W. 2d 761 (Tenn. 1956).

¹⁰² *Spears v. McKinnon*, 168 Ark. 357, 270 S.W. 524 (1925); *Barnett v. Brand*, 165 Ky. 616, 177 S.W. 461 (1915); *Davis v. Kerr*, 239 Pa. 351, 86 Atl. 1007 (1913).

¹⁰³ 164 F. Supp. 716 (D. Minn., 1958), *aff'd*, 273 F. 2d 376 (8th Cir. 1959).

*Salgo v. Stanford University Board of Trustees*¹⁰⁴ was a similar team surgery case. The patient suffered paralysis following injection of barium into the aorta to facilitate x-rays. The procedure had been prescribed by Dr. Gerbode, a professor at Stanford University Medical School, and a specialist in cardiovascular surgery. He was present only at the beginning of this aortography and gave no specific instructions to the team of physicians doing the procedure consisting of a surgeon, an anesthesiologist, and a radiologist. Dr. Gerbode, as attending surgeon in charge of the case, was not liable as he had no control over the activities of the team. On such facts his only liability would be for failure to use proper care in the selection of the team and in the determination of its competence.

In some team surgery cases the doctrine of *res ipsa loquitur* has been applied. Its use is another factor in the picture of expanding hospital liability. This doctrine asserts that the fact of injury speaks for itself and permits the jury to infer that the defendant was negligent without further proof of negligence. Applicability rests upon the presence of three conditions. First, the injury must be of the kind that does not ordinarily happen without negligence; second, the injury must be caused by an instrumentality solely within the control of the defendant; and, third, plaintiff must be free from contributory negligence. The appellate court in *Salgo v. Stanford University Board of Trustees*,¹⁰⁵ held that *res ipsa loquitur* could not be applied because there was testimony to the effect that the unfortunate result of the aortography could have happened even if the injection had been administered properly. This is to be compared with the leading California case of *Ybarra v. Spangard, et al.*¹⁰⁶ The plaintiff patient went to the hospital for an appendicitis operation. Following the surgery the plaintiff suffered paralysis of an arm which medical experts testified was caused by pressure applied between the right shoulder and the neck. Suit was brought against the patient's physician, the surgeon, the owner and operator of the hospital, an anesthetist employed by the hospital and two nurses. Plaintiff was unable to prove that any particular act of any particular defendant caused his injury. The court applied the doctrine of *res ipsa loquitur* saying that there is an inference of negligence against all of those who had any control at all over the patient's unconscious body and that the patient is entitled to an explanation of their conduct. Otherwise, the court reasoned, the plaintiff would be without a remedy unless someone voluntarily stepped forward and disclosed the identity of the negligent actor. It could be that at trial, one or more of the defendants would be found liable and others

¹⁰⁴ 152 Cal. App. 2d 588, 317 P. 2d 170 (1957).

¹⁰⁵ *Ibid.* 47 Cal. 2d 509, 305 P. 2d 36 (1956).

¹⁰⁶ 25 Cal. 2d 486, 154 P. 2d 687 (1944).

not. Some of the defendant doctors might be found to be independent contractors; if the negligent actor was either the anesthetist or one of the nurses then perhaps the hospital is liable as their employer; further, the borrowed servant rule might apply. The main point is that where the plaintiff lacks proof of specific acts of negligence and where the three conditions of *res ipsa loquitur* are present then the plaintiff is entitled to an explanation from each defendant as to his conduct and his relationship with the others who ministered to the patient during surgery.¹⁰⁷

A review of New York cases shows a distinct trend regarding the applicability of the doctrine of respondeat superior to hospitals. Until recently the leading authority was Justice Cardozo's opinion in *Schloendorff v. Society of New York Hospital*,¹⁰⁸ wherein it was held that a charitable hospital was not liable for the negligence of staff physicians and nurses for the reason that their work involves professional skill not under hospital control and hence they are independent contractors. It was said that the hospital only procures the services of a doctor or a nurse for the patient and does not make them its agents or servants to treat the patient. Only if the hospital were negligent in its selection of doctors and nurses could there be liability. From this grew the notion that there was a difference between medical acts and administrative acts. The hospital was not liable for negligent injury occurring during a medical act, but was liable for a negligent administrative act. This administrative-medical act distinction was also applied to the private for-profit hospital as well as to the charitable hospital.¹⁰⁹ It was in reality a technique for determination of control over the doctor's or nurse's act and has appeared from time to time in decisions from other jurisdictions.

As might have been anticipated, it became difficult to draw a logical line of demarcation between medical and administrative acts. The result was confusion. For instance, the giving of a blood transfusion to the wrong patient was held to be an administrative act¹¹⁰ while the mis-

¹⁰⁷ *Leonard v. Watsonville Community Hospital, et al.*, 47 Cal. 2d 509, 305 P. 2d 36 (1956). (*Res ipsa loquitur* applies against surgeon, assistant surgeons, surgical nurse, and hospital where clamp left in patient's abdomen during operation. Such an injury is ordinarily the result of someone's negligence and all participants may be called upon to meet the inference of negligence against them). *Mondot v. Vallejo General Hospital*, 152 Calif. App. 588, 313 P. 2d 78 (1957). (*Res ipsa loquitur* applies when foreign object left in plaintiff's body even though there was a possibility that said object had been left at a later time when patient under care of another physician).

¹⁰⁸ 211 N.Y. 125, 105 N.E. 92 (1914).

¹⁰⁹ *Steinert v. Brunswick Home, Inc.*, 20 N.Y.S. 2d 459 (1940). (Private for-profit hospital not liable when nurse employed by it prepared by mistake a caustic solution to be injected as an anesthetic for the reason that her act was a "medical act").

¹¹⁰ *Necolayff v. Genessee Hospital*, 296 N.Y. 936, 73 N.E. 2d 117 (1947).

matching of blood in a transfusion was deemed to be medical.¹¹¹ Similarly, the use of an improperly sterilized needle for hypodermic injection was an administrative act,¹¹² while the improper administration of a hypodermic injection was medical.¹¹³ Other similar cases likewise reflect the confusion.¹¹⁴

The doctrine of the Schloendorff case and the corresponding distinction between administrative and medical acts was not applied to state and city hospitals for the reason that as to them governmental immunity had been waived by statute.¹¹⁵ As to governmental hospitals, the institutions were and are fully liable under respondeat superior for a professional employee's negligent act. Furthermore, there was never any distinction in New York between a medical and an administrative act when the act was done by a non-professional employee. In view of these difficulties and variations, the 1957 case of *Bing v. Thunig and St. John's Episcopal Hospital*,¹¹⁶ abandoned all distinction between administrative and medical acts. The court adopted the unrestricted doctrine of respondeat superior and said simply that the hospital is liable for the negligent act of one who is its employee and who was acting at the time of his negligence within the scope of his employment. This includes nurses and staff physicians and surgeons. In the principal case, a nurse during preparation for surgery applied an alcoholic antiseptic solution to the operative area of a surgical patient and in so doing permitted some of the solution to fall onto the operating table's linen. Contrary to general hospital rules she failed to inspect the linen and to remove any that had become contaminated. Later, the surgeon entered and when he touched an electric cautery to the surgical area there was "a smell of very hot singed linen." The patient was burned. The court held the hospital liable for the act of the nurse, saying that the specialized skill of a staff doctor or a nurse should not be the basis of

¹¹¹ *Berg v. New York Society for Relief of Ruptured and Crippled*, 1 N.Y. 2d 499, 154 N.Y.S. 455 (1956).

¹¹² *Peck v. Towns Hospital*, 275 App. Div. 302, 89 N.Y.S. 2d 190 (1949).

¹¹³ *Bryant v. Presbyterian Hospital*, 304 N.Y. 538, 110 N.E. 2d 391 (1953).

¹¹⁴ *Ranelli v. Society of N.Y. Hospital*, 295 N.Y. 850, 67 N.E. 2d 257 (1946). (Failing to place sideboards on bed after decision that they were necessary is administrative). *Grace v. Manhattan Eye, Ear, and Throat Hospital*, 301 N.Y. 660, 93 N.E. 2d 926 (1950). (Failing to decide that need exists for use of sideboards is medical). *Iacono v. New York Polyclinic Medical School and Hospital*, 296 N.Y. 502, 68 N.E. 2d 450 (1946). (The placing of an improperly capped hot water bottle is administrative). *Sutherland v. New York Polyclinic Medical School and Hospital*, 298 N.Y. 682, 82 N.E. 2d 583 (1948). (Keeping a hot water bottle on patient too long is medical). *Capasso v. The Square Sanitarium*, 3 Misc. 2d 273, 155 N.Y.S. 2d 313 (1956). (Nurse set up steam vaporizer and infant patient burned. Held administrative act and hospital liable). *Bakal v. University Heights Sanitarium, et al.*, 277 N.Y. App. 572, 101 N.Y.S. 2d 385 (1950). (Pre-surgical preparation by a nurse of an electric plate in contact with patient's body held medical act).

¹¹⁵ *Liubowsky v. State of New York*, 285 N.Y. 701, 34 N.E. 2d 385 (1941).

Becker v. City of New York, 2 N.Y. 2d 226, 140 N.E. 2d 262 (1957).

¹¹⁶ 2 N.Y. 2d 656, 143 N.E. 2d 3 (1957).

denying the applicability of the doctrine of respondeat superior. The court pointed out that to call the nurse an independent contractor is inconsistent with the ruling that she is an employee for the purpose of workmen's compensation.¹¹⁷ Furthermore, the court rejected the assertion of the Schloendorff case that a hospital only undertakes to procure the services of doctors and nurses for the patient. Rather the hospital does indeed, the court said, treat the patient and acts through its staff doctors and nurses. Hence, the doctrine of respondeat superior should apply to hospitals just as it does to any other employer. Clearly this decision broadens the applicability of respondeat superior and circumscribes the notion that a professional person using his own skill and discretion in the performance of professional duties is an independent contractor. Of course, in order to hold the hospital liable, there must be negligence on the part of the professional person. *Bing v. Thunig*, supra, did not alter the standard of proof required.¹¹⁸

This development in New York appears to parallel earlier cases in England where a hospital has been held liable for the negligence of residence medical officers, house surgeons, x-ray technicians and anesthetists.¹¹⁹

SUMMARY

There are three recognizable trends in the law of a hospital's vicarious liability. The first is a change in attitude toward governmental immunity. The Federal Torts Claims Act, the New York statute, and other statutes cited indicate legislative activity in this area and reasonably forecast that additional statutes will follow. Furthermore, it is probable that courts in the future will be more anxious than heretofore to restrict the scope of governmental immunity at the county and municipal level by creating additional exceptions and modifications through expansion of the concept of what constitutes a proprietary function.

The second trend is the judicial reversal of charitable immunity by those courts willing to give the doctrine of *stare decisis* flexibility to serve current social philosophies. Unless legislatures follow the lead of Kansas in re-establishing immunity by statute, an event which is thought to be unlikely, it is to be anticipated that additional courts will join those who have already overruled or severely restricted the doctrine's scope.

The first two trends merely equate the responsibilities of govern-

¹¹⁷ *Bernstein v. Beth Israel Hospital*, 236 N.Y. 268, 140 N.E. 694 (1923). (1923).

¹¹⁸ *Morwin v. Albany Hospital*, 7 App. Div. 2d 582, 185 N.Y.S. 2d 85 (1959). (Expert Testimony is required to establish malpractice).

¹¹⁹ *Fleming, English Law of Medical Liability*, 12 Vand. L. Rev. 636 (1959). See *Cassidy*, supra note 2. *Collins v. Hertfordshire County Council*, K.B. 598 (1947). *Gold v. Essex County Council*, 2 K.B. 293 (1942). *Roe v. Ministry of Health*, 2 Q.B. 66 (1953).

mental and charitable hospitals with the for-profit hospital and commercial enterprise generally. The third trend in the law of hospital liability is the most significant. It is the increasing tendency, aside from immunity, to impose vicarious liability on facts where none would have been imposed heretofore. By some leading decisions it no longer follows that a professional person using his own skill, judgment and discretion in regard to the means and methods of his work is an independent contractor. The hospital may not in any real sense control the staff physician, intern, or nurse in their medical activities but yet there is frequently vicarious liability for their negligent professional acts. By some courts the payment of a salary is more important than control over the actor's work. Gradually, the test of hospital liability for another's act is becoming simply a question of whether or not the actor causing injury was a part of the medical care organization.

Those courts following the theory of ostensible agency on appropriate facts go even further and find vicarious liability whenever the hospital has led the patient to reasonably believe that another was in its employ and under its control. As has been pointed out, this does not fit the traditional legal tests basing vicarious liability upon the existence of an actual master-servant relationship with the servant acting under the master's control in the furtherance of the latter's business. Neither does it fit the newer development of simply inquiring whether or not the actor was in fact and actuality a part of the hospital organization because it emphasizes appearance rather than the true relationship between the actor and the defendant hospital. Regardless of the social merits or de-merits of the theory as it is stated, it is submitted that courts must use care to strictly limit the concept to facts where the hospital has truly misled the patient regarding the identity of the responsible party. There must be a stopping point somewhere to the imposition of vicarious liability. To misunderstand or misapply the ostensible agency theory can only lead to an indistinguishable line of demarcation between liability and non-liability for another's tortious conduct. In any event, it would appear that the law is developing to a point where the only clear-cut line of demarcation is a situation where the patient himself has clearly and expressly employed and paid his own private physician or nurse. Otherwise the hospital's defense plea that the negligent actor was an independent contractor is likely to be unsuccessful.